

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10308

Reg. Dist. No.

10325

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland b. COUNTY Kent	
Kent MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown	
d. LENGTH OF STAY IN 1b lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne Hosp. (		d. STREET ADDRESS Philosophers Terrace	
3. NAME OF DECEASED (Type or print)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
First Ethel		Middle D. Bramble	
Last		4. DATE OF DEATH Sept. 8, 1959	
5. SEX female		Month Day Year 8 1959	
6. COLOR OR RACE white		5. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 7. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> April 13, 1883	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		8. AGE (In years last birthday) 76 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		9. IF UNDER 1 YEAR Months Doyys Hours Min.	
11. BIRTHPLACE (State or foreign country) Kent Co. Maryland		10. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm. B. Coleman		14. MOTHER'S MAIDEN NAME Anna M. Erdman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Paul Fleming		Address Woodcrest Wilmington, Dela.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 15 minutes	
Fracture base of skull DUE TO Knocked down by automobile			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stepped off curb in front of automobile & knocked	
20c. TIME OF INJURY Month, Day, Year Hour 2:30 p.m. 9/8 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt 213 in Chestertown	
20f. (City or town) down (County) (State) Kent Md.			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Robert W. Farr</i>		DATE SIGNED 9/9/59	
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 9/10/59	
22c. NAME OF CEMETERY OR CREMATORIUM Chester Cem.		22d. LOCATION (City, town, or county) Chestertown, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Willis Wells</i>		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR SEP 11 '59		24b. REGISTRAR'S SIGNATURE <i>Robert W. Farr</i>	
DATE			

1000

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10309

Reg. Dist. No.

## CERTIFICATE OF DEATH

10326

1. PLACE OF DEATH a. COUNTY Kent		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 5 years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Kent	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Philosophers' Terrace		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown		d. STREET ADDRESS Philosophers Terrace		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First James	Middle Alfred	Last Brice	4. DATE OF DEATH September 29 1959	Month September	Day 29	Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 9, 1886	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Brice		14. MOTHER'S MAIDEN NAME Anna L. Moore							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-12-3753		INFORMANT Lawrence S. Brice, Betterton, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary infarct</u>									
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> 10 years									
DUE TO (c) <u>Arteriosclerosis</u> 10 years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>August</u> , 1947, to <u>September 29, 1959</u> , that I last saw the deceased alive on <u>September 23, 1959</u> , and that death occurred at <u>4:45 p.m.</u> from the causes and on the date stated above.						ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE <i>A.C. Dick</i>		M.D.		Chestertown, Maryland		DATE SIGNED 9-29-59			
PHYSICIAN'S NAME (Type) A.C. Dick, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 2, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Still Pond Cemetery		22d. LOCATION (City, town, or county) Still Pond, Kent Co., Md. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Victor N. Kennedy</i>		ADDRESS Still Pond, Md.		24a. REC'D BY REGISTRAR Oct 1 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>			



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

10310

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1		10334		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY		Kent		a. STATE <b>New Jersey</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <b>Chestertown (Rural)</b>		b. COUNTY <b>Burlington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Palmyra</b>		d. STREET ADDRESS <b>67x-3</b>	
3. NAME OF DECEASED (Type or print)		First <b>EDMUND</b>	Middle	Last <b>BROWN</b>	4. DATE OF DEATH Month <b>September</b> Day <b>26</b> Year <b>1959</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1886</b> Jan. 29, 1885	9. AGE (In years from birthday) <b>78</b> 73
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b> <b>Phila.</b>	
13. FATHER'S NAME <b>William</b>		14. MOTHER'S MAIDEN NAME <b>Annie</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>159-05-8505</b>		17. INFORMANT <b>Warren Woodring (cousin)</b> Address <b>Villanova, Pa.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address <b>short</b>			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>929.8</b>		Browning			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Had been drinking. Wash on pier at Worton Creek Marina, near Chestertown, Md. Was missing for about 2 hours. When found, was lying under water, near his</b>		DUE TO (b) <b>Marina, near Chestertown, Md. Was missing for about 2 hours. When found, was lying under water, near his</b> (c) <b>boat at about 5:30 PM. Efforts at resuscitation failed</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>boat at about 5:30 PM. Efforts at resuscitation failed</b>		DUE TO (c) <b>boat at about 5:30 PM. Efforts at resuscitation failed</b>			
20a. EXTERNAL CAUSE WAS PRIMARILY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>See above. Had apparently fallen overboard.</b>			
20c. TIME OF INJURY Month, Day, Year <b>3:30 XXX 9/26/59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>See above</b>	
20f. (City or town) <b>Kent</b>		(County) <b>1</b>		(State) <b>MD</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Robert W. Farr</i>		DATE SIGNED <b>26 September, 1959</b>			
EXAMINER'S NAME (Type) <b>ROBERT W. FARR</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/30/59</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Lakeview Memorial Park</b>	
22d. LOCATION (City, town, or county) <b>Cinnaminson Township N. J.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wells Wells</i>		ADDRESS <b>Chestertown, Md.</b>		24a. REC'D BY REGISTRAR <b>SEP 29 '59</b>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur &amp; Thorne</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

10311

10327

## 1. PLACE OF DEATH

o. COUNTY

KENT.

MARYLAND

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

o. STATE

Md

b. COUNTY

KENT.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

CHESTER TOWN

c. LENGTH OF STAY IN 1b

1 yr.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X CHESTER TOWN

d. NAME OF HOSPITAL (If not in hospital, give street address)

OR INSTITUTION

KENT &amp; QUEEN ANNE'S.

d. STREET ADDRESS

(RURAL)

e. IS RESIDENCE

ON A FARM?

YES  NO 

## 3. NAME OF

(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

Month

Day

Year

S. SEX

M

6. COLOR OR RACE

W.

7. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

8. DATE OF BIRTH

SEP 19, 1912

9. AGE (In years  
last birthday)46  
yrs.

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS.

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

PHILA, PA.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ROBERT EARL BROWN

14. MOTHER'S MAIDEN NAME

MARGARET M. DEVITT.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  
(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

INFORMANT

Address

166-16-0590 Hospital

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		METASTATIC CARCINOMA
151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		6 mo.-
(b) DUE TO of STOMACH.		
(c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)
			(State)

21. I certify that I attended the deceased from 9. 12, 1959, to 9. 18, 1959, and that death occurred at 9. 18, 1959, from the causes and on the date stated above.	ADDRESS (Street, city or town, state)	DATE SIGNED
ACTUAL SIGNATURE A. T. KEEFE, M.D.	CHES. TOWN, MD	9. 19. 59.
PHYSICIAN'S NAME (Type)		

22a. BURIAL, CREMATION, OR REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county)
Burial 9/23/1959	Italy Cross Cemetery	Frederick	Pa.
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Edward J. Kilmer	Millington, Md.	DATE	Sept 24 '59



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10312

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall	
3. NAME OF DECEASED (Type or print) Bertha		First Bertha	Middle Clark
4. DATE OF DEATH Sept. 5, 1959	Month Sept.	Day 5	Year 1959
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 1879
9. AGE (In years last birthday) 80	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Laurence Whaland		14. MOTHER'S MAIDEN NAME Sarah A. Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Walter Clark - Chestertown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		INTERVAL BETWEEN ONSET AND DEATH Caronary Thrombosis	
DUE TO (b) Myocarditis with Myocardial Insufficiency			
DUE TO (c) Arterio Oclausis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 22, 1959</u> to <u>Sept 5, 1959</u> that I last saw the deceased alive on <u>Sept 5, 1959</u> , and that death occurred at <u>12:45 AM</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Norbert C. Nitsch</u> M.D. ADDRESS (Street, city or town, state) <u>Rock Hall, Maryland</u> DATE SIGNED <u>9/6/59</u>			
PHYSICIAN'S NAME (Type) Norbert C. Nitsch			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 8, 1959	
22c. NAME OF CEMETERY OR CREMATORIUM Wesley Chapel Cem.		22d. LOCATION (City, town, or county) (State) Rock Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u>		24a. REC'D BY REGISTRAR DATE SEP 9 '59	
ADDRESS Chestertown, Md.		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Krause</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10313

## CERTIFICATE OF DEATH

Reg. Dist. No.

10328

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 6 Wks.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hosp.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown R.D. 3			
d. STREET ADDRESS Quaker Neck Landing		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Elizabeth Helen Cranor		4. DATE OF DEATH Sept. 15 1959			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/19/75		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeping		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) England		
13. FATHER'S NAME Richard Cross		14. MOTHER'S MAIDEN NAME Margaret Barrow			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Mrs. Edward O'Brien Chestertown 3, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Cerebrovascular disease (c) Advanced age		INTERVAL BETWEEN ONSET AND DEATH 1/2 hr. years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-1-1959 to 9-15-1959, that I last saw the deceased alive on 9-15-1959, and that death occurred at 1:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Harry Paul Ross M.D. 203 N Queen St PHYSICIAN'S NAME (Type) Harry Paul Ross Chestertown Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 17/59	22c. NAME OF CEMETERY OR CREMATORIUM St Johns Catholic Yard	22d. LOCATION (City, town, or county) Rock Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams Chestertown, Md.		ADDRESS	24a. REC'D BY REGISTRAR DATE SEP 17 '59	24b. REGISTRAR'S SIGNATURE Charles & Thorne	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

Date of Birth

Cause of Death

Place of Death

Name of Hospital

Name of Doctor

Address

Name of Hospital

Name of Hospital

Name of Doctor

Address

Name of Hospital

Name of Hospital

Name of Doctor

Address

Name of Hospital

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10314

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 5 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Heights		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown	
3. NAME OF DECEASED (Type or print) Carrie Bryan Davis		d. STREET ADDRESS 7 College Heights	
4. DATE OF DEATH Sept. 21		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27 1889
9. AGE (In years at birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard M. Bryan		14. MOTHER'S MAIDEN NAME Carolyn Deputy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. William E. Davis		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkin's disease DUE TO 201X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) multiple duodenal diverticulosis; hiatus hernia, with hiatus insufficiency	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-12, 1958, to Sept. 21, 1959, that I last saw the deceased alive on Sept. 19, 1959, and that death occurred at 7:00 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE A.C. Dick, M.D. Chestertown, Md. 9-21-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 24/59	
22c. NAME OF CEMETERY OR CREMATORIUM Chester Cemetery		22d. LOCATION (City, town, or county) Chestertown, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR SEP. 25 '59		24b. REGISTRAR'S SIGNATURE Arthur <i>Kerry</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10315

10330

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown adult life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home of daughter		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First George W. Gorsuch, Sr.	Middle	Last
4. DATE OF DEATH	Month Sept. 28, 1959	Day 19	Year 19
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1885
9. AGE (In years last birthday) 74 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
13. FATHER'S NAME George W. Gorsuch	14. MOTHER'S MAIDEN NAME Emma Woodward		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. no	17. INFORMANT Mrs. Edw. Robinson	Address Morgnec Chester town, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized cerebral collapse</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Myocarditis</i> DUE TO (c) <i>Rheumatic fever</i> INTERVAL BETWEEN ONSET AND DEATH 415X 8 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cerebral hemorrhage in 1952 - partial paralysis</i> 19. WAS AUTOPSY PERFORMED? 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-15</u> , 19 <u>59</u> , to <u>9-25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9-27</u> , 19 <u>59</u> , and that death occurred at <u>57</u> , M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>A. C. Dick</u> M.D. DATE SIGNED <u>9-29-59</u>			
PHYSICIAN'S NAME (Type) A. C. Dick		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 9/30/59		22c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery	
22d. LOCATION (City, town, or county) Chester town, Md.		22e. LOCATION (City, town, or county) Chester town, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u>		24a. REC'D BY REGISTRAR DATE OCT 1 '59	
ADDRESS Chester town, Md.		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10331

10316

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Kent																													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown		d. STREET ADDRESS 529 1/2 High St.																													
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent and Queen Anne Co. Hosp.		e. DATE OF DEATH First Edwin Middle Dudley Lost Jarvis		f. DATE OF DEATH Month 9 - Day 16 Year 1959		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.																	
13. FATHER'S NAME John T. Jarvis		14. MOTHER'S MAIDEN NAME Alice Marland		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO Circulatory collapse Chemical peritonitis due to rupture of stomach Carcinoma of stomach		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Chestertown, Md.		(County) Md.		(State) Md.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. ADDRESS (Street, city or town, state) Chestertown, Md.		21. I certify that I attended the deceased from 9-14, 1959, to 9-16, 1959, that I last saw the deceased alive on 9-15, 1959, and that death occurred at 3:45 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE A. C. Dick M.D.		DATE SIGNED 9-16-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 18		22c. NAME OF CEMETERY OR CREMATORIAL Church Hill		22d. LOCATION (City, town, or county) Church Hill, Md.		23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane		ADDRESS Church Hill, Md.		24a. REC'D BY REGISTRAR SEP 21 '59		24b. REGISTRAR'S SIGNATURE Arthur & Grace																					

## CERTIFICATE OF DEATH

Date of Birth

Cause of Death

Place of Death

Date of Death

Age at Death

Sex

Race

Marital Status

Occupation

Employment

Employer

Address

City

State

Zip Code

County

Country

State

Country

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10317

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

10332

1. PLACE OF DEATH a. COUNTY Kent		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b less than 1 day		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Queen Anne's	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne's General		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown, Route 1		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First Josephine	Middle Diane	Last Lloyd	4. DATE OF DEATH September 8 1959
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 2, 1955	9. AGE (in years last birthday) 4 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME Andrew L. Lloyd	14. MOTHER'S MAIDEN NAME Josephine Boyles
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Josephine Lloyd, Chestertown, Md., (mother)	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN INJURY AND DEATH 1-2 days
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 795.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Unknown, but probably Natural Causes Had been apparently in good health until about 4:30PM, when she was found lying on the floor in front of the TV set. She had fallen from a low stool. Was a little stiff, but was conscious and knew members of the family. Was brought to the
(b) DUE TO Causa mortis		
(c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
hospital emergency room, had what seems to have a seizure on the way and		

20d. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>	20e. DESCRIBE HOW INJURY OCCURRED (Enter name of injury in Part I or Part II of Item 19)
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20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>						
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ACTUAL SIGNATURE <i>Robert W. Farr</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 8 September, 1959
EXAMINER'S NAME (Type) ROBERT W. FARR	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Sept. 11	22c. NAME OF CEMETERY OR CREMATORIAL CRUMPTON	22d. LOCATION (City, town, or county) CRUMPTON	(State) MD.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar L. Lane Church Hill, Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE SEP 10 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Lane</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10333

## CERTIFICATE OF DEATH

Reg. Dist. No.

10318

1. PLACE OF DEATH a. COUNTY <b>Kent County,</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>37 Chestertown, Maryland</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent and Queen Anne's Hospital</b>				d. STREET ADDRESS <b>1 Philosopher's Terrace</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>James</b>		First	Middle <b>Dunham</b>	Last <b>McVean</b>	4. DATE OF DEATH <b>9</b>	Month	Day <b>1</b>	Year <b>1959</b>	
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>6-10-87</b>	9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Agriculture Agent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>State Employee</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>James Alexander McVean</b>				14. MOTHER'S MAIDEN NAME <b>Grace Robertson</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-38-8766</b>		INFORMANT <b>Hospital Records</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Paralytic ileus</b> DUE TO 571.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Intestinal obstruction</b> DUE TO (c) <b>Adhesion and regional ileitis</b> DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>8-22</b> , 19 <b>59</b> , to <b>9-1</b> , 19 <b>59</b> that I last saw the deceased alive on <b>9-1</b> , 19 <b>59</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>A.C. Dick</i>		ADDRESS (Street, city or town, state) <b>Chestertown, Maryland</b> DATE SIGNED <b>9-1-59</b>							
PHYSICIAN'S NAME (Type) <b>A.C. Dick</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 5, 1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Evergreen Cem.</b>		22d. LOCATION (City, town, or county) <b>Winchester New Hampshire</b> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. Willis Wells</i>		ADDRESS <b>Chestertown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 8 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Krause</i>			

10333 CEDAR FALLS 30 JUNE 1968

CONFIDENTIAL

SS-3

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10319

10336

Item 9 Film 6249 9/25/59 Inv

Reg. Dist. No.

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
Kent				a. STATE	b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Rock Hall				Rock Hall			
d. NAME OF HOSPITAL (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PR INSTITUTION Ferry Park		Ferry Park					
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month 9 Day 16 Year 1959		
Ella	Thomas	Rambo					
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.		
Female	White		Nov. 4 1886	117 872 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			
House wife		Home		Bridgeton, N. J.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?			
Joseph Bacon		Jennie Craig		U. S. A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT			
No		162-09-5782		Harry C. Lamto			
Address				Bayside Rd Ferry Park, Rock Hall			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Severe Myocardial Damage					
420.0		DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) Atherosclerotic Heart Disease					
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
Diabetes Mellitus							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY		Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
Hour a. m.		19	While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>				
p. m.							
21. I certify that I attended the deceased from		Sept 1959		to Sept 1959		that I last saw the deceased alive on Sept 7 <sup>th</sup> 1959, and that death occurred at 9:30 A.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE		William M. Gatewood, M.D.		ADDRESS (Street, city or town, state)		DATE SIGNED	
PHYSICIAN'S NAME (Type)		William M. Gatewood, M.D.		Rock Hall, Md		9/16/59	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORI		22d. LOCATION (City, town, or county)	
Burial		Sept 19, 1959		Birmingham Cemetery		West Chester, Chester Co., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Norman Wiley 2813 N 3rd Philadelphia				DATE SEP 21 '59		Arthur S. Turner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

10320

Reg. Dist. No.

**10337**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Kent		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near - Chestertown		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) d. STATE Maryland		e. COUNTY Kent	
3. NAME OF DECEASED (Type or print)		First Dorothy		Middle Styer		4. DATE OF DEATH Sept. 5, 1959		Month Day Year Sept. 5, 1959	
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/7/50 29		9. AGE (In years last birthday) 29 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George Patrick		14. MOTHER'S MAIDEN NAME Mary Ellen Goodman							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 20-24-4286		17. INFORMANT Mary Patrick Craumer		Address Mother Baltimore, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 823 X		Internal Injuries to chest							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		b) (b) DUE TO Automobile accident							
c) (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident - crashed into embankment							
20c. TIME OF INJURY Hour o. m. 5:45 A.M. p. m. 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg., etc.) Highway intersection near Chestertown, Md.		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>Robert W. Farr</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) Robert W. Farr		DATE SIGNED 9/7/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/7/59		22c. NAME OF CEMETERY OR CREMATORY Chester Cem.		22d. LOCATION (City, town, or county) Chestertown, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Willis Wells</i>		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR SEP 9 '59		24b. REGISTRAR'S SIGNATURE <i>John W. Frazee</i>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM2. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10321

Reg. Dist. No.

10338

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Chestertown		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Lynch		d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 213				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Robert Earl Styer	Middle	Last	4. DATE OF DEATH	Month Sept. 5, 1959	Day 19	Year
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1926	9. AGE (In years last birthday) 33 yrs.	10. UNDER 1 YEAR Months 3	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Laborer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Augustus Styer		14. MOTHER'S MAIDEN NAME Charlotte A. McCardell						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW11		17. INFORMANT Mary Patrick Craumer		Address Mother -in-Law Baltimore, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH Instantaneous		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 823X		Internal Injuries to chest due to						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Sterring wheel impact auto accident						
DUE TO (b)								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident						
20c. TIME OF INJURY Hour a. m. p. m. 5:45 AM 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway Inersection near Chestertown, Md		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Robert W. Farr				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 9/7/59		
EXAMINER'S NAME (Type) Robert W. Farr								
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 9/7/59		22c. NAME OF CEMETERY OR CREMATORIUM Chester Cem.		22d. LOCATION (City, town, or county) Chestertown, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE SEP 9 '59		24b. REGISTRAR'S SIGNATURE Orilia & Kline		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10322

## CERTIFICATE OF DEATH

Reg. Dist. No.

10339

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Maryland		b. COUNTY		Kent	
Kent		MARYLAND		Maryland		Kent					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		X Rural Chestertown		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Rural Chestertown				X Rural Chestertown				/			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS							
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year			
Richard		J.	Walbert		September	16		1959			
S. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.					
Male	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Aug. 29, 1874	85	Months	Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Retired Farmer		Farm		Maryland		USA					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
Theodore L. Walbert		Unknown									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
		none		Morris Walbert--Chestertown, Md. RFD							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of prostate with metastases</u>						2 years					
177X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b)									
		DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>10-19-58</u> , 19 <u>58</u> , to <u>Sept. 16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept. 15</u> , 19 <u>59</u> , and that death occurred at <u>5:00 p.m.</u> from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED			
ACTUAL SIGNATURE <i>A.C. Dick</i>		M.D.				Chestertown, Md.		Sept. 17, 1959			
PHYSICIAN'S NAME (Type)		A.C. Dick, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)			
Burial		Sept. 19		Centreville		Centreville, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
<i>Edgar L. Lane</i>		Church Hill, Md.		DATE SEP 23 '59		<i>Charles J. Kline</i>					
VS A15 (4) 1SM 9/55											

2-2012

## CERTIFICATE OF DEATH

0250

MAY 2012

MAY 2012

MANHATTAN-STATE-DEPARTMENT-OF-HEALTH-CERTIFICATE-OF-DEATH

NAME  
PLATE

MANHATTAN-STATE-DEPARTMENT-OF-HEALTH-CERTIFICATE-OF-DEATH

MANHATTAN-STATE-DEPARTMENT-OF-HEALTH-CERTIFICATE-OF-DEATH

MANHATTAN-STATE-DEPARTMENT-OF-HEALTH-CERTIFICATE-OF-DEATH

MANHATTAN-STATE-DEPARTMENT-OF-HEALTH-CERTIFICATE-OF-DEATH